MAINE INTEGRATED HEALTH MANAGEMENT SOLUTION
PROVIDER ENROLLMENT FORM (MIHMS_EF_0001)
IN-STATE INDIVIDUAL PROVIDER

The purpose of this form is to enroll individual providers in the MaineCare program. An individual provider is a provider that owns and operates his or her own practice or otherwise provides healthcare services under his or her Social Security Number and a Type 1 Individual NPI. An individual provider may associate to other entities as a rendering provider. An individual provider employed by an organization will be re-enrolled by that organization as a rendering provider when required by MaineCare policy.

This form is not to be used in the following situations:

- An incorporated individual provider is considered to be a provider group for this enrollment and must enroll as a Group. An incorporated individual provider must obtain a Type 2 Organization NPI in addition to a Type 1 Individual NPI and use both NPIs on the In-State Provider Group - Provider Enrollment Form MIHMS_EF_0002.
- Any sole proprietor operating as a provider group must instead complete the In-State Provider Group - Provider Enrollment Form MIHMS_EF_0002.
- Any sole proprietor operating as a facility must instead complete In-State Facility, Agency, or Organization - Provider Enrollment Form MIHMS_EF_0003.

Note that an asterisk (*) following a question or field label in this form indicates required information.

If you are not enrolling an individual provider or have otherwise received this form in error, contact the MaineCare Provider Enrollment Unit at 1-866-690-5585.

BEFORE YOU BEGIN

Ensure that you have enough copies of the following sections before you begin filling in the information:

- If you must provide owner or board member information for multiple owners or board members, you must provide a copy of Section 2 for each owner or board member. To determine whether you must provide this information, refer to the criteria listed in Section 2.
- If you have multiple service locations, you must complete Section 3 for each service location.
- If you are licensed or certified for multiple specialties, you must provide a copy of Section 3, Part B for each specialty that you practice at a service location.

Be sure to print or type information on this form so that it is legible. Use only blue or black ink. Do not use pencil.

Failure to provide accurate, complete information (including provider type and specialty or specialties) could result in delayed processing of your application and/or incorrect claim reimbursement.

SECTION 1. BUSINESS INFORMATION

Part A. Enumeration Information

1. How did you enumerate your National Provider Identification number (NPI)? *

☐ Type 1—Individual

Incorporated individual providers should enroll using form MIHMS_EF_0002. Contact the MaineCare Provider Enrollment Unit at 1-866-690-5585.

2. NPI * Supply your NPI.

_____

3. FEIN and/or SSN *

Note: As an individual provider, you are required to supply your Social Security Number (SSN). You may also supply your Federal Employer Identification Number (FEIN), if available.

☐ FEIN _____ ☐ SSN _____

4. Name *

Note: For individual providers, supply the name in this field in the format LastName, FirstName. Ensure that the name is spelled correctly.

_____

Part B. Contact Information

1. Office Contact

Specify information for the contact person for the provider's office. This person could be the provider, an office manager, or someone else. If there are questions regarding this enrollment application, the MaineCare Provider Enrollment Unit will use the information provided here to contact you or your designee.

Name * _____

Title _____

Email address _____

Communications preference * ☐ Email ☐ Paper

2. Provider Phone Numbers

Specify your business phone numbers, including area code.

Primary Phone * _____

Secondary Phone _____

Emergency Phone _____

Mobile Phone _____

Fax _____

3. What is the provider's gender?*

☐ Male ☐ Female ☐ Unknown or prefer not to indicate

Part C. Address Information

Supply the address and other information that appears on the provider's W-9 form. Note that the information provided in these fields must match the information provided on the W-9 form.

1. Pay-To/W-9 Information

W-9 Name * _____

W-9 Business Name _____

Address 1 * _____

Address 2 _____

ZIP or Postal Code * _____

City * _____

County * _____

State or Province * _____

Country * _____

Type of Tax Entity *
☐ Individual/Sole Proprietor
☐ Corporation
☐ Limited Liability Company (LLC)
☐ Disregarded Entity Corporation
☐ Partnership
☐ Unincorporated Association
☐ Other – please explain: _____

For Exempt Payee, indicate whether the provider is exempt from backup withholding. In general, this does not apply to individuals (including sole proprietors). Corporations are exempt from backup withholding for certain types of payments (for example, interest and dividends). For additional information, refer to the W-9 form instructions (available from the Internal Revenue Service or from http://www.irs.gov).

Exempt Payee? * ☐ Yes ☐ No

SECTION 2. OWNERS AND BOARD MEMBERS

Part A. General Information

In accordance with Form CMS-1513 (Disclosure of Ownership and Control Interest Statement), you must provide the names of all individuals and organizations having direct or indirect ownership interests, or controlling interest separately or in combination amounting to an ownership interest of 5 percent or more in the disclosing entity.

If you must provide owner or board member information for multiple owners or board members, you must provide a copy of this Section for each owner or board member.

You are required to complete Part A for at least one owner. (If the provider is a sole proprietor, the information provided here will be that of the provider.) Unless otherwise indicated, all fields in all parts are required.

All fields except FEIN, End Date, and Address 2 are required when supplying information about a person who is an owner or a board member.

All fields except End Date and Address 2 are required when supplying information about an organization that is an owner. FEIN is required when providing information about an organization.

1. Does the following information apply to an owner or a board member? *

☐ Owner ☐ Board member

2. Name, Tenure, and Address Information

First and Last Name * _____

FEIN _____

Begin Date * _____

End Date _____

Address 1 * _____

Address 2 _____

ZIP or Postal Code * _____

City * _____

County * _____

State or Province * _____

Country * _____

3. Has this person ever been sanctioned, excluded, or convicted of a criminal offense related to Medicare, Medicaid, or any federal agency or program (42 CFR 45)? *

☐ Sanctioned ☐ Excluded ☐ Convicted ☐ None of These

Part B. Owner Relationships

1. If there are owners who are related to each other (as spouses, parents and children, or siblings), you must share those relationships in the space provided. *

If there are related owners, specify two different owners' names and their relationship. Any relationships you specify will read from left to right, such as "Bob Smith is parent of Joe Smith".

If you need additional space for this list, you may attach a separate page. For the attached page, label it at the top margin with Section 2, Part B, #1—Owner Relationships.

If there are no related owners, mark this box. ☐ Otherwise, complete the list below, as applicable.

Owner Name	Relationship (spouse, parent/child, sibling)	Owner Name

2. Does any owner or board member have ownership or control interest in other organizations that bill Medicaid for services? If so, please specify.

If this situation does not apply, mark this box. ☐ Otherwise, complete the fields below, as applicable.

For each organization that qualifies, provide the indicated information below. If more than one organization qualifies, list the following information on an additional page and attach to this application. If you need additional space for this list, you may attach a separate page. For the attached page, label it at the top margin with Section 2, Part B, #2—Medicaid Billing Organizations.

Business Name * _____

NPI * _____

Any prior Medicaid Numbers _____

FEIN or SSN * _____

Address 1 * _____

Address 2 _____

ZIP or Postal Code * _____

City * _____

County * _____

State or Province * _____

Country * _____

Part C. Business Questions

1. **Are there any directors, officers, agents, or managing employees of the institution, agency, or organization who have ever been convicted of a criminal offense related to their involvement in such programs established by Titles XVIII, XIX, or XX? ***

   ☐ Yes
   ☐ No

2. **(Title XVIII providers only) Are there any individuals currently employed by the institution, agency, or organization in a managerial, accounting, auditing, or similar capacity who were employed by the institution's, organization's, or agency's fiscal intermediary or carrier within the previous 12 months? ***

   ☐ Yes
   ☐ No

3. **Has there been a change in ownership or control within the last year? ***

   ☐ Yes, on this date: _____
   ☐ No

4. **Do you anticipate any change of ownership or control within the year? ***

   ☐ Yes, on or about this date: _____
   ☐ No

5. **Do you anticipate filing for bankruptcy within the year? ***

   ☐ Yes, on or about this date: _____
   ☐ No

6. **Is this facility operated by a management company, or leased in whole or part by another organization? ***

   ☐ Yes, the change in operations occurred on this date: _____
   ☐ No

7. **Has there been a change in Administrator, Director of Nursing, or Medical Director within the last year? ***

   ☐ Yes
   ☐ No

8. Is this facility chain affiliated? *

☐ Yes ☐ No
If Yes, the following fields are required:

Name * _____

FEIN * _____

Address 1 * _____

Address 2 _____

ZIP or Postal Code * _____

City * _____

County * _____

State or Province * _____

Country * _____

9. If the answer to the previous question is No, was this facility ever affiliated with a chain? *

☐ Yes ☐ No
If Yes, the following fields are required:

Name * _____

FEIN * _____

Address 1 * _____

Address 2 _____

ZIP or Postal Code * _____

City * _____

County * _____

State or Province * _____

Country * _____

10. Have you increased your bed capacity by 10 percent or more or by 10 beds, whichever is greater, within the last two years? *

☐ Yes ☐ No
If Yes, complete the following fields:

Year of change * _____

Current beds * _____

Prior beds * _____

Part D. Legal Questions

Note: For any question to which you respond "yes", you must provide an explanation in #4 below.

1. Have you or any owner or employee ever had any of the following taken against them? *

An assessment	☐ Yes ☐ No
An administrative sanction	☐ Yes ☐ No
A suspension of payment	☐ Yes ☐ No
A restitution order	☐ Yes ☐ No
A program exclusion	☐ Yes ☐ No
A program debarment	☐ Yes ☐ No
A pending criminal judgment	☐ Yes ☐ No
A pending civil judgment	☐ Yes ☐ No
A judgment pending under False Claims Act	☐ Yes ☐ No
A criminal fine	☐ Yes ☐ No
A civil monetary penalty	☐ Yes ☐ No

2. Have you or any owner or employee ever been in the following situations? *

Convicted of any health-related crimes	☐ Yes ☐ No
Convicted of a crime involving the abuse of a child or an elderly adult	☐ Yes ☐ No

3. Do you or any owners or employees have ownership interest in any entity that provides services to a Medicaid provider or supplier? *

☐ Yes ☐ No

4. For each item to which you responded with Yes in #1-3 above, you must provide an explanation on the lines below. If you need additional space for the explanations in #4, you may attach a separate page. For the attached page, label it at the top margin with <u>Section 2, Part D, #4—Legal Questions</u>.

_____

_____

_____

_____

_____

_____

_____

_____

_____

SECTION 3. SERVICE LOCATION(S)

If you have multiple service locations, you must complete this Section once for each service location. Before you begin, make as many copies of pages 10-18 of the form as needed to document all service locations.

If you are licensed or certified for multiple provider type/specialty pairs and you practice two or more of them at a single service location, you must complete Part B of this Section once for each provider type/specialty pair. Before you begin, make as many copies of Section 3 of the form as needed to document all provider type/specialty pairs.

Part A. Basic Location Information

Supply the following information for your service location. Questions 4 and 6-10 are requested for the MaineCare provider directory and are mandatory for providers participating in the Primary Care Case Management (PCCM) program.

If providing services in the home, indicate the office location, not the addresses of your patients or clients.

1. Service Location Name and Number *

If you are enrolling with multiple service locations, each location must have a unique location name. List all locations. Be sure to list your primary location FIRST.

For each service location name, provide a label that will help you easily identify this service location later, such as "Main Street office" or "Augusta location." Supply the service location names on the following lines:

_____

_____

Your Enrollment Welcome letter will contain the 3-digit service location number assigned to each location.

2. Physical Address *

Is this address the same as the Pay-To/W-9 address that you specified earlier in this application?
☐ Yes—skip to #3. ☐ No—complete the following fields. Do not specify a post office box for this address.

Address 1 * _____

Address 2 _____

ZIP or Postal Code * _____

City * _____

County * _____

State or Province * _____

Country * _____

Phone Number * _____

Fax Number _____

3. Mailing Address *

Is this address the same as the Pay-To/W-9 address that you specified earlier in this application?
☐ Yes—skip to #4. ☐ No—complete the following fields.

Address 1 * _____

Address 2 _____

ZIP or Postal Code * _____

City * _____

County * _____

State or Province * _____

Country * _____

4. Additional Languages Spoken

If you, your colleagues, or other staff members at this service location speak one or more languages in addition to English, check the boxes next to the appropriate languages.

In the boxes below, mark all languages spoken by the staff of the service location. (Required for PCCM providers.)

- ☐ Acholi
- ☐ Afrikaans
- ☐ Albanian
- ☐ Amharic
- ☐ Ampango
- ☐ Apache
- ☐ Arabic
- ☐ Armenian
- ☐ Assyrian
- ☐ Bengali
- ☐ Beti
- ☐ Bohemian
- ☐ Bosnian
- ☐ Bulgarian
- ☐ Bunjabi
- ☐ Burmese
- ☐ Byelorussian
- ☐ Cambodian
- ☐ Cantonese
- ☐ Caribbean English
- ☐ Chamarro
- ☐ Chinese
- ☐ Circasian
- ☐ Croatian
- ☐ Czech
- ☐ Danish
- ☐ Dari
- ☐ Dinka
- ☐ Dutch
- ☐ Egyptian
- ☐ English
- ☐ Estonian
- ☐ Ewe
- ☐ Farsi
- ☐ Filipino
- ☐ Finnish
- ☐ French
- ☐ Gaelic
- ☐ German
- ☐ Greek
- ☐ Guarani
- ☐ Gujarti
- ☐ Haitian
- ☐ Hawaiian
- ☐ Hebrew
- ☐ Hindi
- ☐ Hindustani
- ☐ Hmong
- ☐ Hungarian
- ☐ Ibo
- ☐ Iceland
- ☐ Ilocana
- ☐ Indian (East)
- ☐ Indonesian
- ☐ Isujarati
- ☐ Italian
- ☐ Japanese
- ☐ Kannada
- ☐ Karachi
- ☐ Khmer
- ☐ Kiswahili
- ☐ Konkani
- ☐ Korean
- ☐ Laotian
- ☐ Latvian
- ☐ Lebanese
- ☐ Lithuanian
- ☐ Macedonian
- ☐ Malagasy
- ☐ Malayalam
- ☐ Maltese
- ☐ Mandarin
- ☐ Marathi
- ☐ Meley
- ☐ Micmac
- ☐ Mien
- ☐ Neur
- ☐ Never
- ☐ Nigerian
- ☐ Norwegian
- ☐ Pakistan
- ☐ Pashto
- ☐ Passamaquoddy
- ☐ Persian
- ☐ Polish
- ☐ Portuguese
- ☐ Punjabi
- ☐ Romanian
- ☐ Russian
- ☐ Samoan
- ☐ Serbian
- ☐ Serbo-Croati
- ☐ Shan
- ☐ Shanghai
- ☐ Sign Language
- ☐ Sindi
- ☐ Singalese
- ☐ Slovac
- ☐ Somali
- ☐ South Indian
- ☐ Spanish
- ☐ Srilankan
- ☐ Sudanese
- ☐ Swahili
- ☐ Swedish
- ☐ Tagalog
- ☐ Taiwanese
- ☐ Talan
- ☐ Tamali
- ☐ Tamil
- ☐ Telugu
- ☐ Thai
- ☐ Turkish
- ☐ Twi
- ☐ Ukranian
- ☐ Unknown
- ☐ Urdu
- ☐ Uzbek
- ☐ Vietnamese
- ☐ Visayan
- ☐ Yiddish
- ☐ Yoruba
- ☐ Yugoslavian
- ☐ Zairean

5. Medicaid IDs *

List all of the Medicaid IDs assigned to this service location since calendar year 2005. Separate the IDs with commas.

_____

_____

_____

Questions 6-10 on this page are required for PCCM participating providers. For providers not participating in the PCCM program, the following questions are optional. All responses will be included in the MaineCare Provider Directory.

6. Is this service location accessible to persons with disabilities?

☐ Yes ☐ No

7. Is this service location accepting new patients?

☐ Yes ☐ No

8. What are the minimum and maximum acceptable ages of patients that receive services at this location?

Minimum age: _____ years (For infants, use 0 years.)

Maximum age: _____ years (Greatest value accepted, use 112 years)

9. Is there a gender restriction for patients that receive services at this location?

☐ No restriction ☐ Female patients only ☐ Male patients only

10. Office Hours

For days when services are unavailable, check the box next to Closed. For days when services are available, indicate the times at which this location opens and closes. Be sure to indicate a.m. or p.m. for each specified time. (Noon is 12:00 p.m., and midnight is 12:00 a.m.)

Monday	☐ Closed	_____	☐ a.m. ☐ p.m.	to _____	☐ a.m. ☐ p.m.
Tuesday	☐ Closed	_____	☐ a.m. ☐ p.m.	to _____	☐ a.m. ☐ p.m.
Wednesday	☐ Closed	_____	☐ a.m. ☐ p.m.	to _____	☐ a.m. ☐ p.m.
Thursday	☐ Closed	_____	☐ a.m. ☐ p.m.	to _____	☐ a.m. ☐ p.m.
Friday	☐ Closed	_____	☐ a.m. ☐ p.m.	to _____	☐ a.m. ☐ p.m.
Saturday	☐ Closed	_____	☐ a.m. ☐ p.m.	to _____	☐ a.m. ☐ p.m.
Sunday	☐ Closed	_____	☐ a.m. ☐ p.m.	to _____	☐ a.m. ☐ p.m.

Part B. Provider Type and Specialties

Note: You may only assign one Provider Type to each service location; however, you may assign multiple specialties. If the service location that you are enrolling is licensed or certified for multiple specialties, you must provide a copy of this Part B (pages 13-15) for each specialty. As applicable, complete the following licensure and certification information.

For a list of acceptable provider type and specialty values, refer to the *Reference Guide for Valid Provider Type-Specialty Pairs*.

1. Provider Type *

_____

2. Specialty *

_____

Is this the provider's primary specialty?* ☐ Yes ☐ No

Begin Date: * _____ End Date: _____

3. Specialized Questions

a. Are laboratory services offered in this office/facility? (If yes, you must also provide information in #7 below.)
☐ Yes ☐ No

b. Do you have prescribing/dispensing privileges? (If yes, you must also provide information in #8 below.)
☐ Yes ☐ No

c. Do you plan to provide, or are you currently providing prevention services for adults (age 21 and over)?
☐ Yes ☐ No

d. Do you plan to provide, or are you currently providing Prevention, Health Promotion and Optional Treatment Services for members under 21 (also known as EPSDT)?
☐ Yes ☐ No

e. Are you a licensed Hearing Aid Dealer?
☐ Yes ☐ No

f. ? Are you going to provide mail-order pharmacy services for MaineCare?
☐ Yes ☐ No

g. Are you going to provide Specialty Pharmacy Services for MaineCare?
☐ Yes ☐ No

h. Under which one of these models do you provide home support?

Home Support provided by an Agency:	☐ Yes (number of members served: _____)	☐ No
Shared Living Arrangement:	☐ Yes	☐ No
Family Center Support Model:	☐ Yes (number of members served: _____)	☐ No
Agency ¼ Hour:	☐ Yes	☐ No

For Home Support provided by an Agency or Family Center Support, you must submit your license if you have more than two members.

i. Will you be providing comprehensive targeted case management services to MaineCare members under Section 13 of the MaineCare Benefits Manual?
☐ Yes ☐ No
If Yes, What population will you be providing case management services to:
☐ Children Involved with Protective Services

- ☐ Adults Involved with Protective Services
- ☐ Children with Developmental Disabilities
- ☐ Adults with Developmental Disabilities
- ☐ Children with Behavioral Health Disorders
- ☐ Children with Chronic Medical Care Needs
- ☐ Adults with Substance Abuse Disorders
- ☐ Adults with HIV
- ☐ Members Experiencing Homelessness
- ☐ None

4. License Information

- ☐ Association of Operating Room Nurses (AORN)
- ☐ Division of Licensing and Regulatory Services (Facility Standard)
- ☐ Licensing and Regulatory Services (Residential Care - Level III or IV)
- ☐ Maine Board of Licensure in Medicine
- ☐ Maine Board of Osteopathic Licensure
- ☐ Maine Board of Registration in Nursing
- ☐ Maine Office of Licensing and Registration (ALMS)
- ☐ Massachusetts Board of Registration in Medicine
- ☐ New Hampshire State Board of Medicine
- ☐ State of New Hampshire Online Licensing
- ☐ U.S. Food and Drug Administration (Mammography)
- ☐ Other
- ☐ Multiple

For all license choices except Other and Multiple, supply the number of your license in the Number field and provide dates for the Begin Date field and the End Date field.

If you chose Other or Multiple, you are required to include a photocopy of the license(s) when you submit your application.

For any license selection above except for Other or Multiple, supply the license number and effective dates below.

Number:_____

Begin Date*: _____ End Date*: _____

5. Certificate Information

- ☐ American Board for Certification (ABC) in Orthotics, Prosthetics & Pedorthics
- ☐ Board Certification in Molecular Genetics
- ☐ Council of Accreditation of Rehabilitation Facilities (CARF)
- ☐ Health Resource Services Administration (HRSA)
- ☐ Medicare Certification
- ☐ Psychiatry Board Certification
- ☐ Other
- ☐ Multiple

For all certification choices except Other and Multiple, supply the number of your certificate in the Number field and provide dates for the Begin Date field and the End Date field.

If you chose Other or Multiple, you are required to include a photocopy of the certificate(s) when you submit your application.

For any certificate selection above except for Other or Multiple, supply the license number and effective dates below.

Number: _____

Begin Date*: _____ End Date*: _____

6. Education Information

Note: Education is required for the provider type Behavior Health Clinician with a specialty of Licensed Alcohol and Drug Counselor.

College, University, or Other Educational Institution _____

Last Date of Attendance _____

Degree: ☐ Doctorate ☐ Master's ☐ Bachelor's ☐ Degree not obtained

7. CLIA Information (if Yes to 3a above)

Number: _____ Begin Date: _____ End Date: _____

Level:
- ☐ 0 – No certification
- ☐ 1 – Certificate of compliance
- ☐ 2 – Certificate for provider-performed microscopy procedures
- ☐ 3 – Certificate of accreditation
- ☐ 4 – Certificate of registration (or registration certificate)
- ☐ 5 – Certificate of waiver

8. DEA Information (if Yes to 3b above)

Number: _____ Begin Date: _____ End Date: _____

9. JCAHO Information

Does the provider have a JCAHO number? ☐ Yes ☐ No

Begin Date: _____ End Date: _____

10. NABP Information

Number: _____ Begin Date: _____ End Date: _____

11. Medicare Certificate Information (if Applicable)

Number: _____ Begin Date: _____ End Date: _____

Part C. Program Participation

Note: Complete this Part once for each service location.

1. Does this service location currently participate in the Primary Care Case Management (PCCM) program? *

☐ Yes.
☐ No. Do you want this site to participate in this program? ☐ Yes ☐ No

If this site currently participates in the PCCM program, you must also fill out Part D below.

2. Does this service location currently participate in the Maine Breast and Cervical Health program? *

☐ Yes.
☐ No. Do you want this site to participate in this program? ☐ Yes ☐ No

3. Does this service location currently participate in the MaineRx program? *

☐ Yes.
☐ No. Do you want this site to participate in this program? ☐ Yes ☐ No

4. Does this service location currently participate in the MaineCare Eye Care program? *

☐ Yes.
☐ No. Do you want this site to participate in this program? ☐ Yes ☐ No

5. Does this service location provide non-Medicaid services at the request of Adult Protective Services? *

☐ Yes ☐ No

6. Does this service location provide non-Medicaid services to eligible children and families being served by the Child Welfare Program? *

☐ Yes ☐ No

7. Does this service location provide services to the children covered by the Children with Special Needs (CSHN) program? *

☐ Yes ☐ No

Part D. PCCM Information

Note: Complete this Part only if this service location currently participates in the PCCM program, as indicated in the previous Part of this form. All questions in this Part are required. Otherwise, continue with the next Section.

1. **What is the maximum number of patients in this location's site panel? *** _____

2. **What are the minimum and maximum acceptable ages of patients that receive services at this location? ***

   Minimum age: _____ years (For infants, use 0 years.)
   Maximum age: _____ years (Greatest value accepted, use 112 years)

3. **What limitations are there to the practice? Mark all that apply. ***

   - ☐ Accepting existing patients only
   - ☐ Accepting existing patients and their relatives only
   - ☐ Accepting existing patients and newborns
   - ☐ Accepting existing patients and new obstetrical patients
   - ☐ Accepting existing patients and new obstetrical patients, relatives, and newborns
   - ☐ Accepting existing patients and patients by referral
   - ☐ Accepting existing patients only; no obstetrical patients
   - ☐ Clinical limitations
   - ☐ Female patients only
   - ☐ Family practice, obstetrical and prenatal care
   - ☐ Limited availability for new patients
   - ☐ Local area patients only
   - ☐ Native Americans only
   - ☐ Obstetrical patients only
   - ☐ Native American patients and their spouse and children
   - ☐ Male patients only

4. **Will this service location be an open PCP site (accepting new patients) or a closed PCP site (not accepting new patients)? ***

   - ☐ This service location is an open PCP site.
   - ☐ This service location is a closed PCP site.

5. **What is the 24-hour phone number for this site? ***

   _____

6. **After regular office hours, how are phone calls handled? ***

   Check all that apply.

   - ☐ An answering service contacts the site or a covering Medicaid provider.
   - ☐ An answering machine directs patients to call a covering Medicaid provider.
   - ☐ Call forwarding transfers the calls to another location where someone can contact the site or a covering Medicaid provider.
   - ☐ There is an alternate coverage arrangement. (Explain below.)

   _____

   _____

   _____

7. The Department of Health and Human Services allows you to exclude certain patients from the PCP site when a lawsuit exists between you and the patient or when the patient has been formally discharged from your practice. Complete the fields below.

How many patients are excluded from this location? * _____

What are the Member IDs of the excluded patients? List one per line below.

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

SECTION 4. DOCUMENTATION

Part A. MaineCare Benefits Manual Attestations

For each of the following portions of the MaineCare Benefits Manual, check the box to indicate whether you have read and agree to abide by their terms and conditions. You can find these documents online at http://www.maine.gov/sos/cec/rules/10/ch101.htm.

- Chapter I of the MaineCare Benefits Manual
  - ☐ I attest that I have read and agree to abide by the terms and conditions of this document.
- Chapter II of the MaineCare Benefits Manual, Sections _____
  (please enter each Section of Policy that you intend to submit claims under)
  - ☐ I attest that I have read and agree to abide by the terms and conditions of these documents.
- Mental Health documentation
  - ☐ I attest that I have read and agree to abide by the terms and conditions of this document.

Part B. Documents

Complete each of the remaining enclosed documents, as indicated.

☐ Medicaid Provider Agreement
☐ Non-Medicaid Provider Agreement
☐ Electronic Funds Transfer (EFT) Authorization Agreement (if applicable)
☐ DME Storefront Rider
☐ Certified Public Expenditure Form

SECTION 5. SIGNATURE AND SUBMISSION

Read the following statements and, if you are in agreement with them, sign and date where indicated below. Your application is incomplete without your signature.

I certify that the information contained herein is true, correct, and complete. If I become aware that any information in this form is not true, correct, or complete, I agree to notify the Medicaid Provider Enrollment Unit of this fact immediately. I authorize the Medicaid Provider Enrollment Unit to verify the information contained herein. I understand that a change in the incorporation of my organization or my status as an individual or group biller may require a new application.

_____
(Please print) Provider's name

_____
(Please print) Signatory's name and Social Security Number or Group's Federal Employee Identification Number

_____
Signatory's signature

_____
Today's date

Assemble all documents for mailing. Be sure to include the enrollment form, copies of any licenses and/or certificates and all additional documents. Ensure that the Provider Agreement form has an original signature.

Make and retain a copy of the entire enrollment packet for your records.

Send the original enrollment packet and additional documents to:

MaineCare Provider Enrollment
PO Box 1024
Augusta, ME 04332-1024

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Provider Information	
Provider Name *	
Doing Business as Name (DBA)	
Provider Address	
Street *	
City *	
State/Province *	
Zip code/Postal Code *	
Country Code	

Provider Identifiers Information	
Provider Identifiers	
Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN) *	☐☐☐☐☐☐☐☐☐
National Provider Identifier (NPI)	☐☐☐☐☐☐☐☐☐☐
Other Identifier(s)	
Assigning Authority (Required if Identifier is collected)	

Provider Contact Information	
Provider Contact Name *	
Telephone Number *	
Telephone Number Extension	
Email Address	

Field details	*Description*
Provider Information	
Provider Name	Complete legal name of institution, corporate entity, practice or individual provider.
Doing Business As Name (DBA)	A legal term used in the United States meaning that the trade name, or fictitious business name, under which the business or operation is conducted and presented to the world is not the legal name of the legal person (or persons) who actually own it and are responsible for it.
Provider Address	
Street	The number and street name where a person or organization can be found.
City	City associated with provider address field
State/Province	ISO 3166-2 Two Character Code associated with the State/Province/Region of the applicable Country.
Zip code/Postal Code	System of postal-zone codes (zip stands for "zone improvement plan") introduced in the U.S. in 1963 to improve mail delivery and exploit electronic reading and sorting capabilities.
Country Code	ISO-3166-1 Country Code
Provider Identifier Information	
Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)	A Federal Tax Identification Number, also known as an Employer Identification Number (EIN), is used to identify a business entity.
National Provider Identifier (NPI)	A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers and all health plans and healthcare clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10position, Intelligence free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.
Other Identifiers	Medicaid Id or Atypical Id.
Assigning Authority	Organization that issues and assigns the additional identifier requested on the form. e.g., Medicare, Medicaid
Provider Contact information	
Provider Contact Name	Name of a contact in provider office for handling EFT issues.
Provider Telephone Number	Associated with contact person.
Telephone Number Extension	Associated with Provider Telephone Number.
Provider Email Address	An electronic mail address at which the health plan might contact the provider.

Financial Institution Information

Financial Institution Name *

Financial Institution Address

Street *

City *

State/Province *

Zip code/Postal Code *

Financial Institution Telephone Number

Telephone Number Extension

Financial Institution Routing Number *

Type of Account at Financial institution *

Provider's Account Number With Financial institution *

Account number linkage to provider identifier * (Must match ERA Preference)

☐ Provider Tax Identification Number (TIN)
☐ National Provider Identifier (NPI)

Submission Information

Reason for Submission*	◯ New Enrollment ◯ Change Enrollment ◯ Cancel Enrollment
Include with Enrollment Submission	◯ Voided Check ◯ Bank Letter
Authorized Signature	
Written Signature of Person Submitting Enrollment *	
Printed Name of Person Submitting Enrollment	
Submission Date	(CCYY) / (MM) / (DD)

Field details	*Description*
Financial Institution Information *	
Financial Institution Name	Official name of the provider's financial institution
Financial Institution Street Address, Street	Street address associated with receiving depository financial institution name field.
City	City associated with receiving depository financial institution address field.
State/Province	ISO 3166-2 Two Character Code associated with the State/Province/Region of the applicable Country.
ZIP Code/Postal Code	System of postal-zone codes (zip stands for "zone improvement plan") introduced in the U.S. in 1963 to improve mail delivery and exploit electronic reading and sorting capabilities.
Financial Institution Telephone Number	Associated with financial Institution
Telephone Number Extension	Associated with financial Institution telephone number if any
Financial Institution Routing Number	A 9-digit identifier of the financial institution where the provider maintains an account to which payments are to be deposited.
Type of Account at Financial Institution	The type of account the provider will use to receive EFT payments, e.g., Checking, Saving
Provider's Account Number with Financial Institution	Provider's account number at the financial institution to which EFT payments are to be deposited.
Account number linkage to provider identifier	Provider preference for grouping (bulking) claim payments – must match preference for v5010 X12 835 remittance advice. **
Reason for Submission	
Reason for Submission	Please choose a reason for submission as New Enrollment or Change Enrollment or Cancel Enrollment.
Include with Enrollment Submission	Please choose include with enrollment submission as Voided Check or Bank Letter
Voided Check	A voided check is attached to provide confirmation of Identification/Account Numbers.
Bank Letter	A letter on bank letterhead that formally certifies the account owners routing and account numbers.
Written Signature of person submitting enrollment	The signature of an individual authorized by the provider or its agent to initiate, modify or terminate an enrollment. May be used with electronic and paper-based manual enrollment.
Printed Name of Person Submitting.	The printed name of the person signing the form.
Submission Date	The date on which the enrollment is submitted

**Note

A healthcare provider must proactively contact its financial institution to arrange for the delivery of the CORE required Minimum CCD+ Data Elements necessary for successful re-association of the EFT payment with the ERA remittance advice.

If you do not receive your Electronic Funds Transfer (EFT) payment by Monday each week, please contact Molina Provider Services at 1-866-690-5585. We will research your issue and respond to your inquiry as soon as possible.